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FOR ACTION

RECOMMENDATION FOR FUNDING FROM GENERAL RESOURCES AND SUPPLEMENTARY FUNDS FOR A PROGRAMME IN THE AMERICAS AND CARIBBEAN REGION WITH ANNUAL PLANNING LEVELS NOT EXCEEDING $1,000,000*

SUMMARY

The present document contains a recommendation for funding from general resources and supplementary funds for a programme with an annual planning level not exceeding $1,000,000. The Executive Director recommends that the Executive Board approve the following amount from general resources, subject to the availability of funds, and the following amount in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme listed below.

Country/programme	Amount (United States dollars)		Duration
	General resources	Supplementary funds	
Guyana	3 750 000	3 000 000	1995-1999

A summary of the recommendation follows.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. The necessary adjustments, taking into account unspent balances of programme cooperation at the end of 1993, will be contained in the summary of 1994 recommendations for general resources and supplementary funding programmes (E/ICEF/1994/P/L.3 and Add.1).

GUYANA

Basic data (1992 unless otherwise stated)

Child population (millions, 0-15 years)	0.3
Under-five mortality rate (U5MR) (per 1,000 live births)	65
Infant mortality rate (IMR) (per 1,000 live births)	49
Underweight (per cent moderate and severe) (1981)	22
Maternal mortality rate (MMR) (per 100,000 live births) (1984)	200
Literacy (per cent male/female) (1990)	98/95
Primary school enrolment (per cent net, male/female)	../..
Percentage of grade 1 reaching grade 4	84
Access to safe water (per cent) (1991)	65
Access to health services (per cent) (1993)	89
Gross national product (GNP) per capita (1991)	$430
One-year-olds fully immunized against (percentage):	
tuberculosis	89
diphtheria/pertussis/tetanus	81
measles	76
poliomyelitis	81
Pregnant women immunized against (percentage):	
tetanus	..

The situation of children and women

1. Over the last two decades, the quality of life of children and women in Guyana has deteriorated as a result of stagnating economic growth, declining per capita gross national product (GNP), reduced real income, high inflation and a reduction in spending on social services. In 1988, a structural adjustment programme was introduced which brought about noticeable macroeconomic improvements, but imposed severe social and economic pressure on the majority of the Guyanese people. Between 1985 and 1991, a 76 per cent decline in wages coincided with a 7,270 per cent increase in the consumer price index (CPI). In 1990, the World Bank declared Guyana the poorest country in the western hemisphere, with a per capita GNP of $370.

2. The new Government of Guyana, elected in 1992, has expressed its commitment to the principles of the structural adjustment programme, while attaching the highest priority to human resource development and poverty reduction. This is a daunting challenge, as the servicing of the $2.1 billion national debt absorbs some 75 per cent of export earnings. In addition, the massive emigration of skilled Guyanese seeking a better quality of life has been a determining factor in the decline of the country's physical and social infrastructure.

3. While Guyana is geographically part of South America, economically and socially it belongs to the English-speaking Caribbean Community (CARICOM). The people of Guyana are acutely aware of the slippage that has occurred in their social and economic development. For example, in 1965 the per capita GNP was $653, compared to $437 in neighbouring Barbados; by 1990, Barbados had a per capita GNP of $6,540, while in Guyana the figure had dropped to $370. The rest of the Caribbean also has made remarkable strides in child survival and development; between 1960 and 1991, the infant mortality rates (IMRs) in Barbados and Jamaica dropped fivefold, compared to a twofold decline in Guyana.

4. Much of Guyana's adult population benefited from universal primary education, basic health care for virtually all children and family food security. The high level of investment in social services of 30 years ago is still a buffer against the worst aspects of the country's economic decline. Thus, the country's basic indicators are still relatively better than the per capita GNP suggests. None the less, the social impact of the economic crisis is visible. The quality of social services has declined and Guyana's education and health indicators are today among the lowest in the Caribbean.

5. IMR is currently estimated at 49 per 1,000 live births. Recent unpublished data of the Ministry of Health suggest, however, that this figure could be closer to 53 per 1,000, or even higher. Moreover, the national IMR masks geographic disparities; IMR is markedly higher in the hinterland and remote coastal regions. Approximately 30 per cent of infant deaths occur in the first seven days of life owing to high rates of pregnancy among girls 14 years of age or younger. The most frequent causes of these deaths are foetal immaturity, low birth weight owing to maternal malnutrition and respiratory distress. In 1991, of all live births, 18 per cent were babies with low birth weight. Other major causes of infant deaths include diarrhoeal diseases and respiratory infections.

6. The under-five mortality rate (U5MR) is quite high, at 65 per 1,000 live births. Mortality and morbidity are mainly the result of diarrhoeal diseases (further aggravated by the cholera outbreak in 1992), nutritional deficiencies and acute respiratory infections (ARI). Amerindian children in the hinterland areas are one of the groups most affected by malaria, which has been on the rise since anti-malarial measures were suspended owing to fiscal constraints.

7. The high maternal mortality rate (MMR) of over 200 per 100,000 live births is attributed directly to abortion, toxaemia of pregnancy, haemorrhage and post-delivery sepsis. The underlying causes of death include limited access to appropriate health services and little public confidence in the health system. As in the case of neonatal mortality, other causes include early teenage pregnancy, high rate of iron-deficiency anaemia (76 per cent of pregnant women) and maternal malnutrition. Contributing to those direct causes are a shortage of trained birth attendants among the Amerindian population, a shortage of skilled staff at all levels of the health-care delivery system, low availability of family planning services, the use of abortion as a contraceptive and overwork among women. MMR is highest in hinterland areas and remote coastal regions.

8. Limited access to safe water supply and sanitation services in rural areas and the deteriorating coverage of these services in urban areas contribute to the incidence of diarrhoeal diseases. While access to clean water in urban

areas (94 per cent) is higher than in rural areas, poor maintenance arising from the shortage of spare parts and lack of skilled personnel has reduced quality and coverage in recent years. Nationwide, access to safe water supply is 65 per cent, down from 77 per cent in 1987.

9. Literacy, traditionally high in Guyana, has fallen, school attendance is down and successful completion of primary school has declined. While the primary school completion rate is about 80 per cent, its efficiency, quality and relevance are in question, as increasing numbers of children finishing primary school have not mastered basic skills in literacy and numeracy. Poor school conditions, shortages of teaching materials and massive emigration of highly qualified teachers are major problems.

10. The current education system does not meet the specific learning needs of Amerindian children or disabled children, for whom neither specialized nor integrated education is adequately provided. Over the last five years, the number of street children has increased, as has the number of children who have been shifted from one care arrangement to another, as their parents move within Guyana, or overseas, in search of work. The fragmentation of families and the increasing number of single-parent households and abandoned children is thus another dimension of the economic crisis.

11. The lack of current, reliable data on the extent of poverty in Guyana has been a limiting factor in the preparation of the analysis of the situation of children and women. Census data are currently available only from 1980 and household surveys have not been conducted for over two decades. There is a need to strengthen national institutional capacity for data collection and policy analysis.

12. Guyana has ratified the Convention on the Rights of the Child and is in the process of finalizing its national programme of action, which will address the decade goals of the World Summit for Children.

Programme cooperation, 1990-1994

13. The overall objective of UNICEF cooperation in the current programme cycle has been to mitigate the impact of the structural adjustment programme on children, especially in the area of child health, within the framework of the Government's Social Impact Amelioration Programme strategy.

Child survival and primary health care

14. Effective and coordinated tripartite collaboration between the Government, the Pan American Health Organization (PAHO) and UNICEF raised the coverage of immunization services nationwide. Immunization coverage for all six principal antigens increased from 60 per cent in 1989 to 85 per cent in 1992. In 1993, at the request of the Government, UNICEF agreed to support the provision of vaccines for the period 1993-1995, to sustain high coverage rates as a bridge towards national self-sufficiency. The Government is committed to resuming full responsibility for vaccine supplies by 1996 by reinstating its contribution to the CARICOM revolving fund for vaccines.

15. UNICEF support has also been provided to maternal and child health services in the form of essential drugs, medical supplies and equipment for regional health facilities, logistical support, capacity-building for health planning and programming and staff training of 125 community health workers and health visitors. UNICEF also supported a strong social mobilization movement for the control of diarrhoeal diseases as a rapid response to the cholera epidemic in 1992. An important element of this activity was the involvement of four local non-governmental organizations (NGOs) with the capacity to reach out to communities. The use of oral rehydration therapy (ORT) and oral rehydration salts was expanded and the importance of breast-feeding and proper weaning was re-emphasized. Better ARI management also has been advocated, but ARI control is one of the areas in crucial need of programme planning.

Water supply and sanitation

16. UNICEF support was provided for the rehabilitation and expansion of water supply facilities in 15 rural communities where the incidence of diarrhoeal diseases was extremely high. Approximately 80,000 persons benefited from those activities, which were carried out with community participation and included repair of distribution lines, provision of standpipes at homesteads and construction of three wells with motorized pumps. Sanitation activities included construction of demonstration, ventilated improved pit latrines and community education in hygiene and environmental health.

17. The decision to make rural water supply systems a priority took into account the commitment of such other major donors as the World Bank and the Inter-American Development Bank (IDB), which support the rehabilitation of urban systems.

Education

18. UNICEF collaboration helped to improve the quality of pre-school education nationally and the physical environment of selected day-care centres in depressed areas of the capital, Georgetown. This support benefited 3,000 infants and young children by training pre-school teachers, providing essential educational materials and promoting local production of toys and teaching aids.

19. Support was also provided for a pilot adolescent training project in one region, which fosters better parenting skills for future parents. The project now has been replicated in two other regions and has provided training for 150 youths. An assessment of this component points to the broader focus early childhood development should adopt by re-emphasizing the role of parents as the primary educators of young children.

Women in development

20. UNICEF support to activities to empower women and to advance their economic and social development has focused mainly on income generation and health promotion. A revolving fund was established in collaboration with the Women's Affairs Bureau to provide low-cost credit for women. The project has benefited mainly small-scale food producers who have received basic business training.

The major constraint of this fund has been its limited size, but the fund has highlighted women's need for access to capital. Facts for Life messages were the basis for health promotion activities. Sixty women's groups and 10 regional women's action committees were mobilized for neighbourhood and home visits to promote better health practices and care of young children through face-to-face communication.

Children in especially difficult circumstances

21. UNICEF has advocated the need to review policies and programmes for the growing number of children who lack sufficient protection. UNICEF inputs have focused mainly on street children and children in institutions (e.g., youth offenders), while advocating more holistic approaches to meeting the needs of these children by fostering community involvement in their care. Assistance from the Netherlands Committee for UNICEF has helped in the rehabilitation of two institutions for young offenders and vagrant children. A Government-UNICEF study on the situation of street children has provided a benchmark for setting goals for future interventions.

Advocacy and social policy development

22. Effective advocacy for the adoption of social policies aimed at cushioning the economic and social impact of economic adjustment measures on the most vulnerable groups in the country and for protecting children's rights has contributed to Guyana's ratification of the Convention on the Rights of the Child, its signing of the Declaration of the World Summit for Children and its preparation of a draft national programme of action. The Government is revising this draft and has established a National Commission for Children to oversee the national programme of action process. Activities have increased to raise public awareness of the rights and needs of children and women and to mobilize more alliances inside and outside government for the implementation of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. The prominence that the President of Guyana is giving to social issues, especially those that affect children and women, has facilitated this process.

Lessons learned

23. The main lesson of the evaluation of the current programme of cooperation is that more attention should be paid to measuring progress towards meeting objectives and that centralized sectoral programme management has dampened initiative for implementation at the local level. Clear, goal-oriented plans of action will be required in the new cycle to address problems more directly and to measure the achievement of targets more effectively. Community-level planning, better targeting of the most needy communities, a participatory approach and regular monitoring to ensure sustainability of services are all areas that need improving.

24. The capacity of government organizations to manage social development projects should be strengthened and resource mobilization for this purpose is an urgent priority. The success of the expanded programme on immunization (EPI) has highlighted how coordination among all agencies working for children and

women maximizes the use of limited resources and helps to manage the demands that agencies providing assistance often place on weak national infrastructures.

Recommended programme cooperation, 1995-1999

Estimated annual expenditure

(Thousands of United States dollars)

General resources	1995	1996	1997	1998	1999	Total
Advocacy and social policy	50	50	50	50	50	250
Health and nutrition	250	232	232	232	232	1 178
Basic education	80	80	80	80	80	400
Integrated development	122	140	140	140	140	682
Programme support	248	248	248	248	248	1 240
Subtotal	750	750	750	750	750	3 750
Supplementary funding						
Health and nutrition	130	130	130	130	130	650
Basic education	90	90	90	90	90	450
Integrated development	380	380	380	380	380	1 900
Subtotal	600	600	600	600	600	3 000
Total	1 350	1 350	1 350	1 350	1 350	6 750

Programme preparation process

25. The preparation phase of the new programme of cooperation for the period 1995-1999 coincides with the beginning of the new Administration. It also coincides with the Government's decision to review and revise the draft national programme of action and to initiate work on social sector policies. In opening the 1993 programme strategy meeting in Georgetown, the President pledged that the social sector allocation in the national budget would be increased to 20 per cent, within the current mandate of the Government. The preparation, in 1993, of the report on the analysis of the situation of children and women in Guyana was a timely exercise and is potentially a powerful advocacy tool for influencing policy and public opinion. It is also a major point of reference for developing the national programme of action while, at the same time, highlighting various information gaps and the need for strengthening data-collection systems. The development of the country programme has been a consultative process involving the Government, NGOs and multilateral and bilateral agencies.

Programme goals, objectives and strategies

26. The proposed UNICEF programme of cooperation for the period 1995-1999 seeks to contribute to broader efforts aimed at mitigating the social impact of

economic adjustment measures and further promoting social and human development. Within this context, UNICEF cooperation will focus on the basic needs of children and women as beneficiaries and participants in the national development process. Special emphasis will be placed on supporting interventions aimed at accelerating progress towards the mid-decade goals and goals for the year 2000 and on promoting the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women.

27. The overall objectives of the programme are to support government efforts to achieve the following goals: reducing IMR and U5MR to 40 and 50 per 1,000 live births, respectively; reducing MMR to one half the present level; increasing universal immunization coverage by 10 per cent, to 90 per cent, by 1999; eliminating neonatal tetanus and certifying the elimination of poliomyelitis by 1995; reducing moderate and severe malnutrition by 11 per cent and the prevalence of anaemia among pregnant women to less than 50 per cent; improving the efficiency and quality of the primary school system; and improving conditions of children in especially difficult circumstances.

28. The country programme includes a mixture of strategies combining advocacy and social policy, capacity-building for sustained programme delivery, empowerment of communities and support to the delivery of specific services, particularly in an integrated, area-based programme. A special focus of the programme is to expand and improve the outreach capacity of services to the most under-served rural and urban areas, including the hinterland regions, through an area-based approach. Central to this effort will be support for the empowerment of women and youths, who are potentially the greatest agents for change in these communities.

29. While a separate programme on women in development is not foreseen, a gender analysis has been made of all sectoral programmes. In this way, problems related to the fragmentation of families and the excess burden of work on women and children, especially girls and children without protection, will be addressed through interventions targeting areas with the greatest disparities in social indicators. In addition, through the advocacy and social policy programme, UNICEF will cooperate with national and international agencies in Guyana in order that concerns specific to women, such as the legal protection of their rights and their need for special support systems to allow them to fulfil their multiple roles, are addressed as priorities at national and subnational levels.

30. UNICEF resources will complement the activities supported by other United Nations agencies and bilateral and multilateral donors, such as the World Bank, IDB, the United States Agency for International Development (USAID), the Canadian International Development Agency (CIDA) and the Overseas Development Administration of the United Kingdom of Great Britain and Northern Ireland (ODA).

Advocacy and social policy

31. Advocacy activities will seek to stimulate national dialogue on issues related to achieving the mid-decade goals and goals for the year 2000, children's rights and the elimination of all forms of discrimination against

women, to engender national consensus on protecting the rights of children and women. The sensitization of decision-makers at national and regional levels, and of community and other leaders, will be a major activity in consensus-building, particularly in putting the national programme of action into operation at local government and community levels. Children's participation in advocating respect for their rights will be a feature of the new programme and priorities for advocacy will be an integral part of each sectoral programme.

32. UNICEF will provide technical support to the National Commission for Children to finalize the national programme of action and monitor progress towards the goals nationwide. This will entail a parallel effort to strengthen sectoral collection and analysis of data on children and to support sectoral policy formulation and planning in the key areas for children. UNICEF will support training and technical assistance to improve current systems in these areas.

Health and nutrition

33. This programme aims to contribute to the reduction of U5MR and MMR through support for the expansion and strengthening of the primary health care (PHC) system in coastal areas and in the remote hinterland regions where more rapid progress is essential in order for Guyana to achieve the decade goals. Emphasis will be placed on preventing early pregnancy; providing prenatal services; improving conditions at delivery centres; promoting exclusive breast-feeding and the baby-friendly hospital initiative; reducing micronutrient deficiencies in children and women (in particular anaemia); improving case management of ARI and diarrhoeal diseases, including cholera; sustaining and further increasing immunization coverage; and preventing sexually-transmitted diseases, including the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). The link between access to clean water and hygiene education also will be promoted. All of the above-mentioned activities will be implemented within the framework of the national programme of action and the Caribbean cooperation in health initiative, which sets health goals for CARICOM members for the year 2000.

Basic education

34. UNICEF cooperation will contribute to improving the quality and relevance of primary education nationwide by supporting activities designed to reduce high repetition and drop-out rates. Support will be given to strengthen government capacity for policy formulation and planning of primary education reform that promotes the following strategies: changing teaching approaches from expository methods to participatory child-centred methods through improved teacher training; widening coverage of learning materials; and promoting life skills development. Special emphasis will be given to education for development that addresses ethnic group relations, peaceful conflict resolution and gender equity. Increased involvement of parents and communities in the education process will be encouraged to improve the efficiency and effectiveness of the school system. Activities to promote better parenting will also be integral to this programme. UNICEF will continue to cooperate with the United Nations Educational, Scientific and Cultural Organization (UNESCO) and NGOs in all of

these activities and will facilitate Guyana's interaction with the CARICOM Committee on Reform in Education.

Integrated development in selected communities

35. The overall aim of this area-based programme is to mobilize and empower people living in selected marginalized urban, rural and hinterland communities to engage in problem-solving to improve their lives by focusing on the well-being of children and women as an effective entry point to development. UNICEF-supported activities will be carried out within the framework of the Government's decentralization policies and will include support, particularly for capacity-building and improved outreach for integrated basic services delivery at regional and municipal levels. This effort will be vital to achieving the decade goals for children, as these populations are the most affected by major child-survival, development and protection problems. This focus on improving access, coverage and impact of basic services in selected regions of the country will help to accelerate attainment of national goals. Major priorities will include primary health care (PHC), water supply and sanitation, improved educational facilities, support to children in especially difficult circumstances, data collection and analysis at the subnational level and community mobilization and empowerment.

36. Coordination with government agencies, NGOs, community and religious groups and the private sector will be facilitated to promote cost-effective convergence of services.

Programme monitoring and evaluation

37. The Government and UNICEF will monitor implementation of the proposed programmes through on-site visits, periodic programme reviews and the strengthening of government capacity to analyse indicators. The entire country programme will be subject to a comprehensive mid-term review in 1997, at which time adjustments, if any, in strategies, priorities and resource allocation will be agreed upon between the Government and UNICEF.

38. Special emphasis will be placed on providing technical and operational support for empowering beneficiaries to participate actively in planning, monitoring and evaluation activities. The use of sentinel site survey methods to generate local-level impact and monitoring data, for example, will help local agencies and community members assess progress and be involved in decisions on corrective actions.

Programme support

39. UNICEF will provide the administrative and technical staff required for the effective management of cooperation with the Government. To strengthen UNICEF cooperation during this period, one L-4 international project officer post has been created, effective 1 January 1994, in the Guyana Liaison Office, supported by one National Officer and two United Nations volunteers. The Caribbean Area Office in Barbados will provide supervision and technical and administrative

support on an ongoing basis. The costs of the Liaison Office in Guyana will be covered by the programme budget, while the support from the Area Office will be covered by the UNICEF administrative budget.

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RECOMMENDATION FOR FUNDING FROM GENERAL RESOURCES AND SUPPLEMENTARY FUNDS FOR A PROGRAMME IN THE ASIA REGION WITH AN ANNUAL PLANNING LEVEL NOT EXCEEDING $1,000,000*

SUMMARY

The present document contains a recommendation for funding from general resources and supplementary funds for a programme with an annual planning level not exceeding $1,000,000. The Executive Director recommends that the Executive Board approve the following amount from general resources, subject to the availability of funds, and the following amount in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme listed below.

Country/programme	Amount (United States dollars)		Duration
	General resources	Supplementary funds	
Maldives	3 750 000	2 550 000	1994-1998

A summary of the recommendation follows.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1993, will be contained in the "Summary of 1994 recommendations for general resources and supplementary funding programmes" (E/ICEF/1994/P/L.3 and Add.1).

MALDIVES

Basic data (1992 unless otherwise stated)

Child population (millions, 0-15 years)	0.1
U5MR (per 1,000 live births) (1990)	78
IMR (per 1,000 live births) (1991)	56
Underweight (% moderate and severe) (1990)	40
Maternal mortality rate (per 100,000 live births)	400
Literacy (% male/female)	98/98
Primary school enrolment (% net, male/female)	82/81
Percentage of grade 1 reaching grade 4	80
Access to safe water (%) (1991)	69
Access to health services (%) (1990)	68
GNP per capita (1991)	$460

One-year-olds fully immunized against:

tuberculosis:	99 per cent
diphtheria/pertussis/tetanus:	98 per cent
measles:	98 per cent
poliomyelitis:	98 per cent

Pregnant women immunized against:

tetanus:	95 per cent

The situation of children and women

1. The Republic of Maldives is a coral archipelago of 1,200 islands in the Indian Ocean, 200 of which are inhabited. Apart from the capital Malé, the remaining inhabited islands are grouped into 20 atolls. The economy is based on tourism and fishing, with an annual growth rate of around 8 per cent over the last decade. During the past 10 years, the population grew at an average annual rate of over 3 per cent. Of a total population of 223,000 in 1992, 60,000 lived in Malé. Transportation is difficult and expensive, particularly during the monsoon months.

2. The national programme of action (NPA) was completed by the Government in 1992 and sets the goals for children for the year 2000. The South Asian Association for Regional Cooperation, of which Maldives is a Member State, adopted the "Colombo Resolution on Children" in September 1992, reaffirming the mid-decade and end-decade goals for children in the region. As a result of administrative changes following the presidential election in 1993, a new Ministry for Youth, Women's Affairs and Sports has been created. The Fourth National Development Plan (1994-1996) reflects the goals of the NPA and gives priority to social development, including human resource development; improving services in education, health, water supply and environmentally sound sanitation; and accelerating development in the atolls.

3. Significant progress in child survival has been made in Maldives during the past decade. The infant mortality rate (IMR) declined from 95 per 1,000 live births in 1980 to 56 per 1,000 live births in 1990, and the under-five mortality rate declined from 150 per 1,000 live births in 1980 to 78 per 1,000 live births in 1992. Universal child immunization (UCI) was achieved in 1989 and is being sustained, and the country is well en route towards achieving all the mid-decade immunization goals. Malaria has been eradicated and the diarrhoea case fatality rate was reduced from 0.26 per cent in 1985 to 0.06 per cent in 1991. The major cause of death for children is now acute respiratory infections (ARI).

4. Progress has been made in child development. The net enrolment rate for primary education is above 80 per cent for both boys and girls, compared to below 50 per cent a decade ago. But the quality of and equity in access to basic education remain major problems. Pre-schools often lack teaching and learning materials. Partial data indicate that the number of children who are underweight for their age declined from 50 per cent in 1985 to 40 per cent in 1991. Iodine deficiency disorders (IDD) have not been observed, and vitamin A deficiency is believed to have been eliminated. Approximately 30 per cent of all children and women suffer from iron deficiency anaemia. A national nutrition survey in 1994 will provide more accurate data on the situation.

5. The maternal mortality rate (MMR) is still high at 400 per 100,000 live births, though much lower than the estimated 700 per 100,000 live births in 1980. Traditional birth attendants are responsible for most deliveries, and there is little opportunity for referral to medical services outside Malé. Some 65 per cent of all women marry at less than 18 years of age. Only 50 per cent of couples have knowledge of family planning, and pregnancies are usually too early and too closely spaced. On average, a woman will have been married four times by age 50. Female literacy is reported to be 98 per cent and there is little gender disparity in primary education. But after grade five, girls have limited access to secondary education. Moreover, there are very few opportunities for women in post-school job training. As a result, female participation in the labour force is low and has declined from 25 per cent in 1985 to 21 per cent in 1990.

6. There are significant disparities between living conditions in Malé and the atolls. In 1991, MMR for Malé was 145 per 100,000 live births, whereas it was 483 per 100,000 live births in the atolls. The primary school net enrolment ratio in the atolls was about 20 per cent lower than the national average. Approximately one half of the atoll teachers remain untrained, and those with training have less than eight years of schooling. Approximately 60 per cent of the atoll population have access to safe water supplies and 20 per cent have a household latrine, whereas in Malé, universal access to both safe water and sanitation has been basically achieved.

7. Quantified data on children in especially difficult circumstances are limited. However, known problems include children from broken families; migrant children from the atolls, especially girls; children having difficulties with the law; victims of abuse; and disabled children. The frequent change of parents due to divorce suggests that these problems may be greater than currently estimated.

Programme cooperation, 1990-1993

8. The objectives of the programme of cooperation have been: (a) to enhance child survival and development through interventions such as UCI, promotion of oral rehydration therapy (ORT) and growth monitoring and promotion; and (b) to help reduce the disparities in living conditions between Malé and the atolls by accelerating the development of services in the atolls in primary education, maternal and child health (MCH) care, water supply and sanitation and women-oriented activities.

Child health and growth monitoring and promotion

9. From 1990 to 1993 immunization coverage of children has been sustained at over 90 per cent. Tetanus toxoid coverage for pregnant women increased from 67 per cent in 1990 to 95 per cent in 1992. The country has been polio free since 1981, and no other vaccine-preventable diseases have been reported since 1986, except for a few cases of neonatal tetanus. The Department of Public Health has established a system whereby an outreach team of community health workers provides four rounds of immunizations per year at each atoll health centre. Training was provided for 560 health care workers in appropriate diarrhoea management with oral rehydration salts (ORS) and ORT. Some 50 per cent of mothers know how to prepare the solution correctly, but the actual usage rate for ORT is estimated below 30 per cent. Some 460 family health workers have been trained to monitor and record children's growth, as well as to counsel parents on children's nutrition and on corrective measures to be taken when growth falters. Nearly all children are issued a growth chart at the time of birth and are weighed at least five to six times in the first three years of life.

Education

10. With the construction of 50 primary schools in the atolls with UNICEF assistance, nearly every island now has a primary school. UNICEF also supported curriculum development and the strengthening of an education media unit. Funding support to the Institute for Teacher Education has helped to train 700 teachers for atoll primary schools. Assistance to the Non-formal Education Centre pioneered a condensed education programme for disadvantaged children; a distance education project for the atolls; and a project to establish atoll educator resource centres.

Women in development

11. Support was provided to establish 14 island women's centres, as well as skills development and training and leadership training. So far, only two centres have been completed and are functioning, while the rest are expected to be completed by 1995. The delay is due mainly to the limited staff and management resources of the Department of Women's Affairs. The newly created Ministry of Youth, Women's Affairs and Sports will be strengthened in planning, implementing and monitoring activities.

Water supply and sanitation

12. UNICEF provided materials for the construction of about 600 community and 1,800 household ferro-cement rainwater collection tanks on 100 islands. This helped to increase the access to safe water in the atolls to 62 per cent. Household tanks are constructed on a cost-recovery basis and repayment is improving considerably. Progress in sanitation has been slower. A more suitable type of latrine system needs to be designed to appeal to more families. The Government has recently established a unit at the Department of Public Health for health and hygiene education in collaboration with the media. This will help to strengthen hygiene education, which so far has been weak.

Evaluation and lessons learned

13. The mid-term review held jointly by the Government and UNICEF in 1992 recommended the application of successful experiences in child survival to other goals, including expanding the commitments of the Government, as reflected in its significant budget increase for primary health care and education; strengthening the capacity of outreach teams for services in the atolls; and community co-financing for water collection tanks. The main constraints to anticipate and manage are: the limited management resources of the coordinating ministries and the atoll and island development committees; a serious shortage of trained human resources in atolls; and limited access of women to information, education and communication.

Programme objectives and strategies

14. In the first phase of the programme (1994-1995), the aim will be to assist the country to achieve the mid-decade goals, i.e. to sustain immunization coverage of the six antigens of the expanded programme on immunization (EPI) at above 95 per cent; to maintain zero cases of measles and polio; to eliminate neonatal tetanus; to increase the ORT usage rate to 80 per cent; to achieve exclusive breast-feeding for the first four to six months of life; to reduce iron deficiency anaemia to 20 per cent; and to confirm that IDD and vitamin A deficiency are not prevalent. In the second phase of cooperation, from 1996 through 1998, the programme will help to achieve the end-decade goals in the NPA, which include reducing IMR to 25 per 1,000 live births and MMR to 100 per 100,000 live births; increasing primary education completion to 95 per cent and adult literacy to 100 per cent; reducing the number of children who are underweight for their age from 40 per cent in 1990 to 10 per cent; and providing universal access to safe water supplies and sanitation.

Recommendation programme cooperation, 1994-1998

Estimated annual expenditure

(In thousands of United States dollars)

	1994 a/	1995	1996	1997	1998	Total
General resources						
Children's and women's health and development	250	280	280	260	260	1 330
Education	230	220	220	250	250	1 170
Nutrition	50	50	50	50	50	250
Water supply and environmental sanitation	170	150	150	130	120	720
Advocacy and social mobilization	30	30	30	40	40	170
Programme support	20	20	20	20	30	110
Subtotal	750	750	750	750	750	3 750
Supplementary funding						
Children's and women's health and development	200	275	275	300	300	1 350
Education	75	125	125	100	100	525
Water supply and environmental sanitation	50	100	100	100	100	450
Children in especially difficult circumstances	25	50	50	50	50	225
Subtotal	350	550	550	550	550	2 550
Total	1 100	1 300	1 300	1 300	1 300	6 300

a/ A total of $547,000 was already approved by the Executive Board for the year 1994 as part of the previous programme cycle. An increase of $203,000 in general resources is being requested for 1994.

15. The basic strategies to achieve the goals are: (a) strengthening of service delivery, especially in low-performing atolls; (b) capacity-building through human resource development, systems development in Government and strengthening atoll development committees in programme planning, implementation and monitoring; (c) community empowerment, especially women's development, through multisectoral approaches focusing on the transfer of skills and knowledge; and (d) advocacy for the rights of children and women, including greater attention to maternal mortality, gender issues and resource mobilization, including community co-funding.

Children's and women's health and development

16. The achievement of EPI-related goals will be sustained. The Government will gradually assume full responsibility for vaccine supplies and maintenance of the cold chain. The national ARI programme will be supported jointly by the

World Health Organization (WHO) and UNICEF to accelerate screening and case management at household and health centre levels. To promote the use of ORT and continued feeding during episodes of diarrhoea, ORT/ORS units will be established on all 200 islands for counselling and monitoring purposes, and intensive training for case management will be provided for 20 atoll-level health centres.

17. Technical assistance will be provided for the newly established Ministry of Youth, Women's Affairs and Sports to develop a national policy on women and to create awareness of gender issues. In collaboration with the Department of Public Health and the atoll and island development committees, the Ministry will complete the 12 remaining island women's centres by 1995 and extend the programme experiences to more than 100 islands by 1998. The island women's centres will serve not only for MCH activities as in the previous country programme, but also for community education on children's and women's health, marriage, child spacing, nutrition, hygiene, skills and job training for women and women's credit schemes. Training will be provided for the staff of the four regional health centres and their outreach teams to review all maternal deaths and to strengthen the skills of health workers to identify high-risk cases.

Nutrition

18. The national nutrition survey supported jointly by UNICEF, WHO and the All India Institute of Nutrition will be completed in mid-1994. The survey will analyse the need for proper breast-feeding and weaning practices, child care, hygiene, sanitation and proper food and cooking, and will call for a greater emphasis on family and community action and the empowerment of mothers through a multisectoral programme. The survey should also confirm that the IDD and vitamin A deficiency mid-decade goals have been achieved. Continued advocacy, training and monitoring for the promotion of breast-feeding and the Baby-Friendly Hospital Initiative will be supported, since at present all babies are given glucose water during the first two days of life. Iron deficiency anaemia will be addressed through increased awareness of the nutrition needs of the girl child and the distribution of iron folate tablets at antenatal clinics.

Education

19. In order to improve the quality of and access to education in the atolls, 20 atoll educator resource centres will be established and strengthened to provide training to 700 local primary schoolteachers. Teaching and learning materials will be developed and provided to all the island schools, and school libraries will be developed, since reading materials are scarce. About 30,000 primary schoolchildren will benefit. The Ministry of Atoll Administration, the Ministry of Education and the Ministry of Youth, Women's Affairs and Sports will plan and undertake these activities jointly. Distance education through radio education programmes will be explored. The above-mentioned ministries, in collaboration with the island development committees and island women's centres, will develop home-based approaches for early childhood development. Training will be provided for some 200 traditional pre-schoolteachers to benefit at least 8,000 children under six years old.

Water supply and environmental sanitation

20. Support will continue for the construction of community and household rainwater collection tanks through community financing to further increase the coverage of safe water supplies from 62 per cent to 100 per cent in the atolls. Household latrine construction will be supported, and a consultant is working on the design for appropriate technologies to be adopted. To increase the coverage of household latrines from the present 30 per cent in the atolls to 100 per cent will be a great challenge, but acceleration is possible through community and family financing. Support will be provided to the Hygiene Education Unit of the Department of Public Health for developing education and communication materials on hygiene education, and training will be provided to health workers through the regional outreach teams for advocacy and monitoring purposes.

Children in especially difficult circumstances

21. The programme will provide support for the implementation of the Convention on the Rights of the Child. A law on children's rights was adopted in 1992, and the Government has formed a National Council for follow-up on the Convention. Support for the National Council will continue through the training of 270 counsellors for parents and community leaders. A situation analysis on the magnitude of the problem of children in especially difficult circumstances nation-wide will open the way for the development of more concrete objectives and strategies.

Programme management

22. UNICEF assistance is expected to play a catalytic role in the country's efforts to achieve the mid-decade and end-decade goals, requiring advocacy and support to the Government, as well as close collaboration with community leaders for actions at local levels. To strengthen staff capacity, a new international project post was established, initially for 1994, and will be extended through 1998 upon the approval of the proposed country programme. This post will be in addition to the post of assistant representative, which is at present the sole international post in UNICEF Malé.

23. Close collaboration with other United Nations agencies, including the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA) and WHO, as was carried out in the process of programme formulation, will continue in programme resource mobilization, implementation, monitoring and evaluation. UNDP, UNFPA and UNICEF now share common premises. Donors such as the Japan National Committee for UNICEF, the Netherlands National Committee for UNICEF, the Swiss National Committee for UNICEF, the United Kingdom of Great Britain and Northern Ireland National Committee for UNICEF and the Organization of Petroleum Exporting Countries contributed greatly to the past programme cycle, and their continued support will be essential.

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FOR ACTION

RECOMMENDATION FOR FUNDING FROM GENERAL RESOURCES AND SUPPLEMENTARY FUNDS FOR A PROGRAMME IN THE MIDDLE EAST AND NORTH AFRICA REGION WITH AN ANNUAL PLANNING LEVEL NOT EXCEEDING $1,000,000*

SUMMARY

The present document contains a recommendation for funding from general resources and supplementary funds for a programme with an annual planning level not exceeding $1,000,000. The Executive Director recommends that the Executive Board approve the following amount from general resources, subject to the availability of funds, and the following amount in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme listed below.

Country/programme	Amount (United States dollars)		Duration
	General resources	Supplementary funds	
Djibouti	3 500 000	3 750 000	1994-1998

A summary of the individual recommendation follows.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1993, will be contained in the "Summary of 1994 recommendations for general resources and supplementary funding programmes" (E/ICEF/1994/P/L.3 and Add.1).

DJIBOUTI

Basic data (1992 unless otherwise stated)

Child population (millions, 0-15 years)	0.2
Under-five mortality rate (U5MR) (per 1;000 live births)	158
Infant mortality rate (IMR) (per 1,000 live births)	113
Underweight (per cent moderate and severe) (1990)	23
Maternal mortality rate (MMR) (per 100,000 live births) (1989)	740
Literacy (per cent, male/female) (1985)	15/9
Primary school enrolment (per cent net, male/female)	45/33
Percentage of grade 1 reaching grade 4 (1988)	89
Access to safe water (per cent) (1991)	84
Access to health services (per cent) (1990)	86
Gross national product (GNP) per capita (1991)	.. a/
One-year-olds fully immunized against (percentage):	
tuberculosis	84
diphtheria/pertussis/tetanus	84
measles	83
poliomyelitis	81
Pregnant women immunized against (percentage):	
tetanus	89

a/ GNP per capita is estimated to be in the $500-$1,499 range.

The situation of children and women

1. Progress in child survival, development and protection in Djibouti has been limited by a lack of national capacity, weak economic growth and the unstable political situations inside the country and in the Horn of Africa. As a result, most of the children and women of Djibouti live in poverty. Djibouti is an almost entirely arid land with no mineral or other natural resources, water is scarce and there is limited agricultural potential. The frail economy is able to absorb less than 60 per cent of the labour force, and most of those employed earn only subsistence wages. Ninety-five per cent of Djibouti's food supply consists of imports, which are among the most expensive in Africa. As a result of these and other socio-economic indices, Djibouti ranks 163 out of the world's 173 countries, according to the United Nations Development Programme (UNDP) Human Development Index. Moreover, poverty may be increasing due to declining trade with Ethiopia and Somalia.

2. Internal conflict has led to the destruction of health centres and schools in the northern districts, where the fighting has been concentrated. It is

draining a large portion of the government budget, which would otherwise be allocated to development activities. The internal conflict is creating a climate of uncertainty and instability, which is detrimental to efforts to provide basic services. In addition, some 40,000 people have been displaced from their homes.

3. Another serious problem is the unstable and impoverished conditions that characterize the Horn of Africa region as a whole. Djibouti's economy, highly dependent on neighbouring Somalia and Ethiopia, has been severely affected by the unrest in those countries. The presence of approximately 120,000 displaced persons, refugees and nomadic Somalis and Ethiopians in Djibouti's population of 520,000 is placing a major strain on the country's meagre resources. It is estimated that these groups from neighbouring countries utilize a major portion of resources for health services. The continuous inflow of refugees also makes it difficult to control communicable diseases effectively and complicates the implementation of other basic services, such as primary education.

4. With an annual population growth rate of over 3 per cent, the country's population is projected to double in just 22 years. Fifty-two per cent of the population are under 20 years of age. The country is highly urbanized - nearly 75 per cent of the population is concentrated in Djibouti City. Most of the refugees live in shanty towns, in the streets of Djibouti City or in four refugee camps.

5. In 1992, the infant mortality rate (IMR) was estimated at 113 per 1,000 live births and the under-five mortality rate (U5MR) at 158 per 1,000 live births. Both IMR and U5MR were found to be 20 points lower for boys than for girls. Lack of proper prenatal and delivery care services, maternal malnutrition and anaemia and obstetrical complications arising from female genital mutilation contribute to high neonatal mortality. The most important determinants of infant mortality are acute respiratory infections (ARI) and diarrhoeal diseases, both acting in concert with malnutrition. Deaths from vaccine-preventable diseases, largely reduced in recent years, also remain a potential threat among the one fourth of the population who are rural nomads and among newly arrived, unimmunized refugee children. Acquired immune deficiency syndrome (AIDS) is spreading and is increasingly a threat to children.

6. Malnutrition is a major contributing factor to virtually all deaths of children under five years of age. A nationwide survey in 1990 revealed that 11 per cent of infants were acutely malnourished and 22 per cent were chronically malnourished. Women, on average, breast-feed for just five months; only 42 per cent of mothers still breast-feed at six months and just 10 per cent at 12 months. At age two months, one fifth of infants are fed solid food. However, hospitals and health centres, where 60 to 70 per cent of deliveries take place, are being exposed to the Baby-Friendly Hospital Initiative (BFHI). Three hospitals met the BFHI criteria in 1992 and another four did so in 1993. All health facilities no longer give out free infant formula and they are promoting exclusive breast-feeding during the first four to six months.

7. A 1989 national survey by the Ministry of Health, in cooperation with the World Health Organization (WHO) and UNICEF, estimated the maternal mortality rate (MMR) to be 740 per 100,000 live births, the highest in the region. Based

on a fertility rate of seven, 1 out of every 20 pregnant women will die from pregnancy-related causes. Major immediate causes of maternal mortality include haemorrhage, infection, obstructed labour, pre-eclampsia and eclampsia. Complications from female genital mutilation, maternal malnutrition and anaemia, high fertility and short birth intervals and lack of adequate antenatal, perinatal and post-natal care are all important indirect causes. The practice of female genital mutilation remains almost universal.

8. A lack of high-quality primary education prevents the majority of children from achieving basic literacy, numeracy and other important life skills. The net enrolment for primary school in 1991 was only 39 per cent. The situation is particularly bad for girls, whose enrolment is only 33 per cent as compared to 45 per cent for boys. The rate of repetition averages about 12 per cent annually and also reflects the shortcomings of the education system in meeting basic learning needs. Literacy among adults (over 15 years of age) is among the lowest in the world, 9 per cent for women and 15 per cent for men.

9. All of the above-mentioned circumstances illustrate the tremendous challenges facing the country in achieving the decade goals for children. However, there are opportunities as well. There is a high level of government attention to children's issues. The Government has ratified the Convention on the Rights of the Child; endorsed the goals of the World Conference on Education for All; signed the Declaration of the World Summit for Children; and, most importantly, integrated a national programme of action for the survival and protection of children during the 1990s into its 1991-1995 national plan.

10. The process of democratic reform in the country has created a climate more conducive to attention to the needs of children and women. There is a large network of community leaders and groups committed to the promotion of children's issues. The country's small size serves to foster close working relations among organizations concerned with the situation of children and women. With a population of about 500,000 concentrated in a small area, communication and awareness-raising campaigns are able to reach communities rapidly and effectively.

Previous programme cooperation

11. UNICEF cooperation during the 1980s focused on the promotion and implementation of primary health care (PHC), especially for universal child immunization (UCI). Cooperation also included the promotion of oral rehydration therapy (ORT), breast-feeding and supplementary feeding to reduce child malnutrition.

12. When the national immunization programme was launched in 1984, vaccination services were limited to a small number of urban children and the national coverage level was 7.5 per cent. There was a highly centralized, hospital-based health system, as well as little public awareness of the importance of immunization. UNICEF, in close collaboration with the Ministry of Health, WHO, the French Cooperation Mission and the National Union of Djiboutian Women, played a leading role in the formulation and launching of the national expanded programme on immunization (EPI) campaign. UNICEF provided vaccines, disposable needles and syringes and cold-chain equipment and expertise and sponsored social

mobilization campaigns and training of health workers and vaccinators. WHO and UNICEF also worked closely with the Ministry of Health to integrate immunization services with other PHC services. As a result, UCI was achieved in 1989, a target which had widely been perceived as impossible. In 1992, vaccination coverage for all six antigens and tetanus toxoid for pregnant women was sustained at more than 80 per cent. Pockets of low coverage in localities affected by civil strife continue to exist. In addition, with a large influx of unvaccinated refugee children, there is a potential for the resurgence of vaccine-preventable diseases. UNICEF also supported the provision of oral rehydration salts (ORS) and essential drugs for an outbreak of cholera in 1993.

13. UNICEF cooperation has also focused on the situation of women in terms of health, education and the overall social status of women. UNICEF provided supplies and equipment for all of the country's maternal and child health (MCH) centres and supported the training of nurses, midwives and traditional birth attendants (TBAs). More than three quarters of women now have access to prenatal care and supervised deliveries. Still, 1 out of every 20 pregnant women dies of pregnancy-related causes because the quality of services is low, and the status of women remains low.

14. Extensive efforts were made to empower women and girls through the national literacy/life skills programme, which was launched in 1991. The programme makes use of facilities and teachers from the formal school system and provides two-hour classes four evenings a week during the school year. The first hour of each class is devoted to developing core functional literacy and numeracy skills, using real life examples, while the second hour is devoted to developing general life skills and knowledge. The programme provides a choice of either French or Arabic for the reading and writing component, and of either Somali, Afar or Arabic for the life skills component, for 4,000 women.

Lessons learned

15. Although the survival and development of women and children has been high on the government agenda, progress was impeded by, inter alia, a lack of adequately trained managers and a continuing influx of refugees and displaced persons. Achieving the mid- and end-decade goals will require reaching more displaced and squatter populations with basic services. Particular emphasis should be placed on improving the capacities of the health system for controlling communicable diseases, AIDS, malaria and tuberculosis.

16. Raising awareness of mothers, and in fact of entire families, has not been sufficiently a part of all major programmes. Therefore, priority should be given to more effective and sustainable communication and social mobilization activities. The high drop-out rate among women in the literacy programme, in spite of their strong demand for learning opportunities, strongly suggests that the conceptual, organizational and funding elements of the programme need to be revised. More involvement of women community leaders in programme planning and management could reinvigorate the programme.

17. More efforts should focus on strengthening government capacities in programme management, which would include preparedness for and response to emergency situations and their linkages with regular national programmes.

Training in setting up improved mechanisms for monitoring and evaluation at the different administrative levels of service delivery also needs to be one of the top priorities during the next cooperation period.

Recommended programme cooperation, 1994-1998

Estimated annual expenditure

(In thousands of United States dollars)

	1994	1995	1996	1997	1998	Total
General resources						
Health	180	345	340	330	325	1 520
Education	150	165	165	165	160	805
Advocacy and planning	30	30	25	25	25	135
Programme support	140	210	220	230	240	1 040
Subtotal	500	750	750	750	750	3 500
Supplementary funding						
Health	590	575	495	480	495	2 635
Education	100	160	235	250	230	975
Advocacy and planning	60	15	20	20	25	140
Subtotal	750	750	750	750	750	3 750
Total	1 250 a/	1 500	1 500	1 500	1 500	7 250

a/ Additional funds in the amount of $250,000 for the January-April 1994 period were approved by the 1993 UNICEF Executive Board in a separate proposal (E/ICEF/1993/P/L.25).

18. Government/UNICEF cooperation during the period 1994-1998 will include three interrelated and mutually supportive programmes: health; education; and advocacy and social planning. The country programme will address four major goals, the first three being (a) to reduce IMR from 113 per 1,000 live births to 60 and U5MR from 158 per 1,000 live births to 80; (b) to reduce MMR from 740 per 100,000 live births to 370; and (c) to reduce severe and moderate malnutrition among children under five years of age by at least 50 per cent. These goals are based on the national programme of action and on the National Five-Year Plan, 1991-1995. The fourth goal, to empower all women and girls with the basic knowledge and skills needed for healthy living, was adopted in view of the inextricable link between basic education as an empowerment strategy and the overall well-being of children and mothers. All programme activities will be linked with these four national goals for children for the 1990s.

19. The programme formulation process led to the identification of a number of cross-cutting strategies, the most important of which are (a) developing national capacity; (b) a more focused strategy on the needs of urban slum dwellers; (c) community empowerment through increasing the basic skills and knowledge of families; (d) reducing gender gaps by improving the situation of girls; (e) promoting stronger linkages and coordination between development agents; and (f) mobilizing community and religious leaders as leaders in child survival, development and protection. These cross-cutting strategies will permeate the country programme.

Health

20. This programme will be comprised of four projects: MCH and nutrition; control of childhood diseases; urban community health; and control of AIDS.

21. The objective of the MCH and nutrition project is to help to reduce by 50 per cent malnutrition among children under five years of age and maternal mortality, and to improve the prenatal and post-natal health status of mothers. This will involve increasing the awareness and actions of health workers and families regarding the importance of proper maternal and child nutrition; early, exclusive and prolonged breast-feeding; maternal care; family planning; and the harmful nature of traditional practices such as female genital mutilation. Relevant information will be widely disseminated through television and radio spots, information materials based on Facts for Life and community outreach by child health workers, Imams (Islamic religious leaders) and schoolteachers. UNICEF will support capacity-building through in-service training for health staff on breast-feeding, growth monitoring and promotion, safe motherhood and family planning. Special information tutorials for TBAs will give priority to issues such as the harmful consequences of female genital mutilation. UNICEF will also support the establishment of nutrition information and rehabilitation centres at selected health dispensaries, provide child scales and growth monitoring and promotion charts for use in health dispensaries, and advocate for the establishment of institutions and legal provisions in support of breast-feeding.

22. The control of childhood diseases project will help to reduce mortality and morbidity caused by ARI and diarrhoeal and vaccine-preventable diseases in children under five years of age and will aim to eliminate neonatal tetanus and substantially reduce the incidence of measles and poliomyelitis. These objectives can be achieved if all displaced and squatter child populations are immunized to control disease transmission. Therefore, it is planned to support annual multi-antigen national campaigns to boost the high coverage already achieved through regular service delivery. UNICEF will provide vaccines, needles, syringes and cold-chain equipment for EPI. To combat diarrhoeal diseases, a capacity-building strategy will include the promotion of correct case management through the supply of ORS and the promotion of ORT, the training of health staff and the provision of diagnostic charts and treatment manuals. Support will also include the development of visual aids, printed materials and mass media spots directed at all family members and child care workers. Other activities will include public information seminars on community hygiene and sanitation, and religious leaders, TBAs, child health workers and teachers will be mobilized as communication agents. Major strategies to control

ARI will include establishing standardized case management at all health centres and raising public awareness that ARI is a major killer of children.

23. A major effort to address specifically the problems of refugees and displaced families will be made through the urban community health project in Balbala, which is a peri-urban slum area housing over 110,000 of the country's most disadvantaged women and children. The main objective of the project is to accelerate delivery of services for the control of diarrhoeal diseases and ARI, essential drugs, family planning, prenatal and post-natal care, growth monitoring and promotion, breast-feeding and maternal nutrition. The activities will be managed from the four Balbala health dispensaries and a hospital, and will be implemented under the direct supervision of newly established local technical committees. These local committees are linked closely with their corresponding national committees in each of the major programme areas. Particular emphasis will be placed on capacity-building through the training of health staff and the provision of health education equipment and supplies, improved reporting systems and monitoring and evaluation. Support will also be provided for expanding and improving two ongoing community empowerment initiatives: (a) systematic outreach by trained community health workers (CHWs); and (b) upgrading the quality of traditional community health care through the training of TBAs. The lessons learned and experience gained in Balbala will be used for developing similar programmes in other under-served peri-urban areas and for improving the national MCH programme.

24. In close cooperation with WHO, a project will be implemented to prevent the human immunodeficiency virus/AIDS by raising public awareness through the work of CHWs with high-risk groups such as sex workers and youth. A wide dissemination of information materials and mass media spots, along with the mobilization of religious leaders, TBAs, CHWs and women's literacy teachers will be essential in promoting AIDS awareness. A regional AIDS information and resource centre will be established, with WHO and UNICEF assistance, to serve as a focal point for region-wide AIDS prevention and regular experience exchange for health professionals and other concerned groups. A non-governmental organization (NGO) will serve as an AIDS contact group and will register high-risk populations and provide them with AIDS prevention information and regular medical examinations.

Education

25. While overall promotion of universal primary education will be important, the education programme will focus on increasing the access of girls and women to basic numeracy and reading/writing and life skills through both the formal school system and non-formal education. A basic capacity-building strategy is to upgrade the quality of formal primary education, while building a responsive non-formal system for wider coverage. The formal component will centre on improving the relevance of learning by incorporating the themes of Facts for Life into teacher-training programmes and primary school curricula. It will also selectively upgrade poor environmental conditions of schools in outlying rural areas so as to create a more acceptable environment for girls to attend school. Nationwide non-formal education will focus on reaching girls and women who cannot be reached by the formal system at this time. A community-based learning programme for out-of-school girls and women will be established. The

curriculum will combine basic numeracy and reading/writing skills with life skills, for example, health, hygiene, environmental care, nutrition and family income skills related to fishing, farming and handicrafts. This programme will also include Facts for Life learning for women. It will teach life skills subjects in the local languages of Afar and Somali, and basic literacy and numeracy skills in either of the official languages of French and Arabic. Special radio programmes on Facts for Life will be broadcast twice each evening for half an hour in Arabic and French to promote appropriate family health practices and to reinforce newly acquired skills and knowledge. In developing a network of non-formal education centres for women and girls, efforts will centre initially on reorienting the existing network of nine youth houses. The libraries at the centres will be supplemented with a variety of materials.

Advocacy and planning

26. The advocacy and planning programme will be composed of two components, advocacy and capacity development. The advocacy component will help to raise the profile of women's and children's issues generally, and in particular will increase public awareness of and concern for child rights. UNICEF, through its membership in the Higher Council for the Protection of Children and Mothers and the national programme of action subcommittee for child rights, will assist the Government with the incorporation of provisions of the Convention on the Rights of the Child into the country's laws and judicial practices. The increased involvement of religious leaders as advocates for women and children will help to promote stronger ethics for children. UNICEF will support the production of multi-media communication materials that address important issues, for example, the promotion of UCI, the use of ORT and harmful traditional practices. The establishment of a non-governmental child rights advocacy group will also be supported. It will disseminate public information on the Convention on the Rights of the Child, sponsor educational programmes and documentaries for television and radio and organize seminars and workshops for the mass media.

27. The capacity development component will aim at improving planning, monitoring and evaluation for the implementation of the national programme of action. Sectoral subcommittees, under the National Intersectoral Committee for Follow-up on the World Summit Goals, will be established. They will refine sectoral strategies for national programme of action goals, upgrade databases and reporting systems for the national programme of action and monitor the progress of implementation. UNICEF will provide technical assistance for setting up an information management system for analysing and evaluating indicators related to the World Summit and national programme of action goals in relevant government ministries and statistical centres. UNICEF will also support training of health staff at the peripheral, district and central levels in data collection and analysis, record-keeping and reporting systems and the design and conduct of surveys.

Monitoring and evaluation

28. Along with specific emphasis on monitoring and evaluation of the national programme of action, monitoring progress and evaluating achievements in relation to objectives of the proposed cooperation will be important for all programmes. Monitoring and evaluation capacities will be strengthened through more efficient

use of routine reporting systems, feedback from field workers, cost-effectiveness appraisals and national household health and health facility surveys planned for 1994 and 1997. Monitoring and evaluation systems will be based on major indicators for each programme, for example, access, coverage and impact indicators. Annual programme reviews will be conducted during the last quarter of each calendar year under the coordination of the Ministry of Cooperation and with the participation, as and where appropriate, of United Nations agencies and other interested parties. These reviews will identify programming adjustments and resource allocations for annual project plans of action. A mid-term programme review, supported by relevant evaluation studies, will be undertaken in mid-1996; it will analyse overall trends and progress towards objectives and assess the effectiveness of strategies. The situation analysis of children and women will be updated annually and will figure prominently in the mid-term and annual reviews.

Inter-agency cooperation

29. The programme of cooperation will complement the activities of other United Nations agencies. Health activities will involve continued close collaboration with WHO and increased cooperation with UNDP and the United Nations Population Fund, particularly in the fields of family planning, safe motherhood and prevention of AIDS. Activities in the nutrition sector will involve collaboration with the World Food Programme and the Food and Agriculture Organization of the United Nations. The United Nations Educational, Cultural and Scientific Organization will be an important partner in efforts to incorporate basic life skills and knowledge into primary school curricula and in developing non-formal education for girls and women. Other international partners include the Italian Cooperation Mission, the primary implementing partner in the urban community health project; the French Cooperation Mission, active in both the health and nutrition sectors; the European Union, involved in the development of PHC, AIDS prevention and a variety of other areas; and the Inter-Africa Group, active in the fight against female genital mutilation.

30. Increased emphasis will be placed on cooperation with national NGOs and local groups in all programmes as part of the empowerment strategy to develop community capacity. Major national NGO partners will include the National Union of Djiboutian Women, which is active in safe motherhood promotion, girls' non-formal education and women's learning of life skills, and the Centre for Research, Information and Production of Education, which is involved in the development of learning materials, textbooks and radio programmes with Facts for Life themes. Local groups and leaders, including Imams and other religious leaders, local community health committees, municipal leaders, social service providers, TBAs, CHWs and non-formal education teachers will have important roles in all elements of the country programme.